

city of **NEWPORT BEACH**



benefits

**Active Employees
Information Guide For
Plan Year 2013**

The new plan changes for Plan Year 2012 are as follows:

CalPERS Kaiser HMO:

- There are no plan changes for 2013.

CalPERS Blue Shield:

- Partnership with Teladoc Inc. to provide subscribers with 24/7/365 access to doctors by phone or secure video. Teledoc doctors are U.S. board certified and can be used for non-emergency issues. Physicians can also write prescriptions which can be called into a local pharmacy.

CalPERS Blue Shield NetValue

- Adding providers in San Bernardino and San Diego Counties.

CalPERS Select

- Expanding service area all counties in California.

CalPERS PERS Choice, PERSCare and PERS Select Plans

1. Adding more hip and knee replacement facility centers in California.

PORAC:

- There are no plan changes for 2013.

Prescription Benefit Basics (CalPERS):

CVS Caremark(Does not apply to CalPERS PORAC plans)

- CalPERS selected CVS Caremark to administer prescription benefits for PPO plans effective January 1, 2012.
- Maintenance Choice Program -allows members to pick up a 90-day supply of medication directly from a CVS pharmacy at their convenience. Members will pay their typical mail order co-pay for a prescription on the same day and be able to talk face-to-face with a pharmacist.
- Members are able to save money by choosing "best choice" medications (generics and preferred brands) and 90-day supplies, where appropriate, in the iBenefit personalized mailing program.

Dental & Vision Plans: The City will remain with Delta Dental and SafeGuard Vision. There are no plan changes for 2013.

YOUR BENEFITS

The City of Newport Beach is proud to provide our employees with a competitive benefits package which includes: medical, dental, vision, life, flexible spending accounts (FSAs), an employee assistance program (EAP), short and long-term disability and supplemental voluntary life insurance.

Dependents that are Eligible for Benefits

Under the CalPERS plans, your dependents are covered to age 26, regardless of their student status or economic dependence. Dependents over age 26 are not covered under the CalPERS medical plans. For dental and vision coverage, dependents are covered to age 26 as well.

YOUR HEALTH CARE BENEFITS

Medical

HMO (Health Maintenance Organization)

An HMO is a medical plan that requires you to receive all of your care from within a network of participating physicians, hospitals, and other health care providers. In order to be covered for benefits, or be referred to a specialist, you must access medical care through your primary care physician (PCP). To find a PCP near you, call the health plan, refer to its provider directory, or visit its website. HMOs currently offered:

- **CalPERS Blue Shield HMO**
- **CalPERS Blue Shield NetValue HMO**
- **CalPERS Kaiser Permanente HMO**

PPO (Preferred Provider Organization)

A PPO is a medical plan that lets you choose between in-network providers who offer their services at discounted rates and out-of-network providers. You may see any in- or out-of-network provider; however, it costs you less if you see an in-network provider. Also, you do not need a referral to make an appointment to see a specialist. The following PPOs are currently offered through CalPERS:

- **PERS Choice - Administered by Blue Cross**
- **PERS Select - Administered by Blue Cross**
- **PERSCare - Administered by Blue Cross**
- **PORAC (PORAC dues paying members only) - Administered by Blue Cross**

For information about services covered under the medical plan options, refer to the *Medical Plans Comparison Chart*.

Dental

DHMO (Dental Health Maintenance Organization)

When you enroll in a DHMO dental plan, you must select a dental office from the plan's provider directory. After you select your dental office, this office becomes your "primary care office" and you will go to this office for all of your dental care services. If you do not obtain dental care services from this office, you will not be covered. If your primary care office is unavailable during an emergency, call the dental plan and ask for a referral. You pay no deductible or co-payment for preventive services under a DHMO dental plan. For most other services, you must pay a copayment or predetermined fee.

There is no annual maximum dollar limit on DHMO dental benefits. The following DHMO plan is currently offered:

- **Delta HMO Dental**

PPO

A PPO dental plan allows you to choose care from in-network or out-of-network providers. When you obtain care from in-network providers, the plan pays higher benefits and your out-of-pocket costs are lower. **In-Network**—When you receive care from an in-network dentist, you pay no deductible. Delta Dental will pay benefits based on fees that have been agreed upon by Delta Dental and its participating dentists. The costs of most routine services are 100% covered. **Out-Of-Network**—When you receive care from an out-of-network dentist, you pay a \$50 deductible, with a \$150 maximum per family. The plan pays benefits according to what is considered reasonable and customary (R&C) for the service and area. Since Delta Dental and out-of-network dentists have not agreed upon fees, the dentist may charge more and your out-of-pocket costs could be higher. The following PPO dental plan is offered:

- **Delta PPO Dental**

For information about services covered under the dental plan options, refer to the *Dental Plans Comparison Chart*.

Vision

You have the option of obtaining vision care services through the SafeGuard PPO Vision plan. SafeGuard Vision offers coverage for exams, glasses, contact lenses and related vision services through its network of preferred providers. SafeGuard Vision also provides limited coverage for some services received by out-of-network providers.

If you use a SafeGuard Vision in-network provider, SafeGuard covers the full cost, for you and your enrolled family members for the following:

- One vision exam every 12 months, after a \$10 deductible
- Corrective lenses every 12 months
- Frames every 12 months from an approved list of covered frames up to \$100 retail value
- Contact lenses, if determined medically necessary or \$250 (\$125 per lens) towards the cost of fitting and materials once every 12 months (in lieu of other vision materials). Non-medically necessary contact lenses used for cosmetic purposes are also covered, at a lesser benefit amount.

Refer to the *Vision Summary* chart for a list of covered services.

Flexible Spending Accounts (FSA)

FSAs enable you to set aside pre-tax dollars to cover qualified expenses that you would normally pay out of your pocket with after-tax dollars. You pay no federal income, state income, or Social Security taxes on the money that you set aside in an FSA. Therefore, your take-home pay increases.

- **Health Care Flexible Spending Account**

When you "open" an HCFSA, you tell the City to put part of your pay into an account on a pre-tax basis. This is your tax-free money to use for eligible health care expenses for you and your family, even if you or your dependents are not enrolled in the City's medical, dental, and/or vision plans. Eligible health care expenses are those that are not covered by other medical, dental, or vision plans. Examples include:

- Medical and dental deductibles, coinsurance, and copayments
- Medicines/Prescriptions
- Vision care—including prescription glasses, contact lenses, and laser eye surgery
- **Note: You may contribute a minimum of \$130, up to a maximum of \$2,500 per year.**

- **Dependent Care Flexible Spending Account (DCFSA)**

The DCFSA allows you to set aside pre-tax dollars for certain eligible dependent care expenses. You may contribute a minimum of \$1,000, up to a maximum of \$5,000 per year to your DCFSA.

- **Please note that a Flex Card debit card is available.**

Beginning in 2012, FSA participants were issued Flex Cards with a 3 year expiration date. Therefore, it is the vendor's intent that employees continuing their participation in the program in 2013 will not receive new cards. Employees participating for the first time will receive a new card. A second card is available free of charge by contacting Employee Benefit Services (EBS). Additional and replacement cards are available for \$10.00 per card. You will have the option to use these cards if you desire, however their usage is not required. You will still have the option to complete claim forms manually. When the Flex Card is used, the funds are pulled instantly from your FSA account without having to use cash or credit cards, filing a claim, and having to wait for the reimbursement. This does not eliminate your responsibility to keep the purchase receipt. **It is an IRS requirement that all receipts for items purchased with the Flex Card are saved. The IRS, as well as EBS, can ask for substantiation at any time, and therefore receipts will be required as proof of an eligible purchase. EBS would ask for substantiation within 30 days, but the IRS can ask for those receipts in an audit.** The cards are accepted at doctor's offices, select stores, pharmacies and daycares where VISA and MasterCard are accepted. The cards are activated the first time they are used. Personal identification numbers are not required to use the card. If the cashier asks for a PIN, then the card can be run through as "credit".

- **Note:** Direct deposit is available under these programs.

Life Insurance Beneficiary

Now is a good time to update your life insurance beneficiary form. With the many changes that go on in our everyday lives, it's easy to forget to update this important information. Stop by or call HR to get a new beneficiary form for completion.

Q&As: Important information

Q: *What should I know about the City's Opt-Out program?*

A: If you provide proof of other **group** medical insurance coverage, you may be eligible to waive coverage under the City of Newport Beach group health insurance plans and receive the taxable cafeteria allowance each payday. **Whether or not you have waived coverage in previous years, it is necessary for you to provide supporting documentation each Open Enrollment period.**

Q: *I chose one of the CalPERS PPO plans; do I need a referral to see a specialist?*

A: If you have elected a PPO plan (PERSCare, PERS Choice, PERS Select or PORAC), you may select any provider and make an appointment. Occasionally, your PPO provider may refer you to a specialist or for other services such as diagnostic testing. You should verify that the referral is to a PPO network provider to reduce your out-of-pocket expenses. You may have to satisfy a deductible before benefits are payable under the plan, even if you choose a network provider. After you have satisfied your deductible, the plan will pay a percentage of coinsurance and you will be responsible for the remainder. The percentage paid by the insurance will be based on whether or not your provider is a PPO network provider. Please refer to the benefit booklet for your plan for complete details.

Q: *What happens if I acquire or lose dependents after I enroll in the City's Health Benefits Program?*

A: Employees must contact Human Resources within **60 days of an event**, such as a marriage, birth, adoption, divorce, or death to make changes to their health plans (additions or deletions). Coverage will be effective the 1st day of the month following the qualifying event. Forms must be completed and filed with the various insurance carriers to accomplish the change. If you do not complete and return these forms to Human Resources within 60 days of the qualifying event date, your dependents will not be eligible for enrollment until the next Open Enrollment period.

Q: *What are my options regarding changes in coverage under my spouse's group plan?*

A: If you currently opt-out of the City's coverage and your spouse loses his or her coverage, due to a qualifying event (i.e. loss of job), you may enroll in one of the

City's plans, but you **must** complete and return the appropriate forms to Human Resources **within 60 days** of the loss of coverage. If you are enrolled in one of the City's plans and you wish to enroll in your spouse's group plan due to a qualifying event (i.e. marriage, new coverage available) you may opt-out of the City's plan by providing valid proof of other **group** medical insurance coverage and you **must** complete and return the appropriate forms to Human Resources **within 60 days** of the date of the qualifying event or effective date of new coverage.

Q: *I am planning on retiring. What is the City's retiree health benefit program?*

A: The City has a Medical Expense Reimbursement Program (MERP). If an employee is opting out of coverage and retires from the City, they have 120 days to elect enrollment in health, dental and/or vision coverage. You can change plans or continue the same coverage at each Open Enrollment. Failure to elect any City plan (medical, dental or vision) within 120 days from your retirement date will render you permanently ineligible from the dental and vision plans. You may, however, enroll in any CalPERS plan at the next Open Enrollment.

If an employee is opting out of coverage, you can choose a CalPERS medical plan at the time of your retirement, as long as you meet the following CalPERS requirements:

- If you have between 30 and 120 days between your separation date and your retirement date, you may re-enroll within 60 days of your retirement date or during Open Enrollment.
- If you separate from City employment and do not retire within 120 days into the CalPERS retirement system, you are **not** eligible for medical coverage through CalPERS at any future date.

Employees that were eligible and elected the Hybrid option of the MERP program, will receive a monthly \$400 contribution (minus the PERS mandatory employer contribution if applicable) into their MERP account whether they are enrolled in a City-sponsored plan or not.

Q: *What is HIPAA and how does it affect me?*

A: The Health Insurance Portability & Accountability Act (HIPAA) regulations in regards to protected health information (PHI) went into effect April 2004. These regulations affect how your personal health information can be utilized and who can access it. These rules limit the City's ability to assist in your claim issues (i.e. disputes, billing, complaints, etc.). Employees must contact their insurance carriers directly for all claim issues or complete an authorization form. This form can be obtained from Human Resources.

BENEFITS CONTACT INFORMATION

	Phone Number	Web Site
PERS MEDICAL PLANS		
Blue Shield HMO & Blue Shield Net Value	Member Services: 800-334-5847 Rx: 800-334-5847 Mail Order - nextRx: 800-293-2202	www.blueshieldca.com
Kaiser Permanente HMO	Member Services: 800-464-4000	www.kaiserpermanente.org
PERS Choice PPO	Member Services: 877-737-7776 Rx - CVS Caremark: 800-542-0284	www.anthem.com/ca/calpers www.caremark.com/calpers
PERS Select PPO	Member Services: 877-737-7776 Rx - CVS Caremark: 800-542-0284	www.anthem.com/ca/calpers www.caremark.com/calpers
PERSCare PPO	Member Services: 877-737-7776 Rx - CVS Caremark: 800-542-0284	www.anthem.com/ca/calpers www.caremark.com/calpers
PORAC PPO/Indemnity	Member Services: 800-288-6928 Rx - Express Scripts: 866-876-0333	www.anthem.com/ca/calpers www.express-scripts.com
DENTAL & VISION PLANS		
SafeGuard Vision	Member Services: 800-880-1800	www.safeguard.net
Delta HMO Dental	Member Services: 800-422-4234	www.deltadental.com
Delta PPO Dental	Member Services: 800-765-6003	www.deltadental.com
FLEXIBLE SPENDING ACCOUNTS (FSA)		
EBS (Employee Benefit Specialists)	Member Services: 888-327-2770 Automated Voice System: 800-EBS-FLEX Fax: 925-460-3929	www.ebsbenefits.com
MEDICAL EXPENSE REIMBURSEMENT PROGRAM (MERP)		
OptumHealth Financial Services	Investments/Balances: 877-365-7923	www.ohfsbenefitaccess.com